



Department of Medicaid

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TO: Contracted Managed Care Organizations
Contracted MyCare Ohio Plans

FROM: James Tassie, Deputy Director
Office of Managed Care

DATE: February 1, 2023

SUBJECT: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program

The purpose of this correspondence is to reiterate certain requirements of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program, otherwise known as Ohio Medicaid's Healthchek Program. As you are aware, Medicaid managed care organizations (MCOs) and MyCare Ohio plans (MCOPs) must ensure that members under the age of 21 have access to services that are available in accordance with federal EPSDT requirements found at 42 U.S.C. 1396d(r) as amended. This includes medically necessary services covered by Ohio Medicaid, as well as any medically necessary screening, diagnostic and treatment services available to Medicaid consumers pursuant to 42 U.S.C. 1396d(a) that go beyond the applicable coverage and limitations set forth in Division 5160 of the Ohio Administrative Code (OAC).

Prior Authorizations/Coverage Determinations for EPSDT

- OAC rule 5160-1-01 stipulates two medical necessity definitions: one for individuals covered by EPSDT (any individual under age 21 with access to state plan services), and a second for individuals not covered under EPSDT. MCOs and MCOPs must ensure that staff and/or delegated entities are educated regarding the two different medical necessity definitions.
- Prior authorizations and coverage determinations must be reviewed for medical necessity as defined in OAC rule 5160-1-01(A).
- Prior authorizations and coverage determinations requests that include an invalid code, include a code that is not on the Medicaid fee schedule, or exceed Ohio Medicaid coverage and/or limitations for individuals age 21 or over must still be reviewed for medical necessity for individuals under age 21. While it is understood that providers ultimately must submit a claim with a code that will be accepted, it is critical that access to a medically necessary service is not denied and/or delayed solely due to a coding issue. MCOs, MCOPs, and/or delegated entities must make their prior authorization and coverage determination while working with the provider to identify an applicable code for billing purposes (e.g. MCOs and MCOPs may have to have the claim submitted with a miscellaneous code).

Information to Members/Providers to Reflect EPSDT

- Notices to members or providers (e.g. denial reasons on notices of action, state hearing forms/appeal summaries, etc.) must explicitly indicate that prior authorization and coverage determinations are based on medical necessity.

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- To clearly reflect that MCOs, MCOPs, and/or delegated entities are utilizing the correct definition of medical necessity when making prior authorization and coverage determinations, MCOs and MCOPs must cite OAC rule 5160-1-01(A), at a minimum, as the supporting regulation for their decision.
- Any MCO, MCOP, and/or delegated entity policies, materials that reflect coverage (e.g. prior authorization lists), and/or benefit limitations must prominently include a disclaimer such as “providers can request prior authorization to exceed coverage or benefit limits for members under the age of 21.”
- Explanation of Payment (EOP) or Explanation of Benefit (EOB) notices must clearly reflect that coverage decisions for members under the age of 21 are based on medical necessity for services available to Medicaid consumers pursuant to 42 U.S.C. 1396d(a).

Questions regarding the above information should be send to ManagedCarePolicy@medicaid.ohio.gov.